MEDPAC Medicare Payment Advisory Commission

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Francis J. Crosson, M.D., Chairman
Jon B. Christianson, Ph.D., Vice Chairman
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November 16, 2015

Andrew Slavitt, Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington DC, 20201

Dear Mr. Slavitt:

The Medicare Payment Advisory Commission (MedPAC) welcomes the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Request for Comment memorandum entitled "Proposed Changes to the CMS-HCC Risk Adjustment Model for Payment Year 2017" issued by the Medicare Plan Payment Group on October 28, 2015. The memorandum proposes changes to improve the way that the Medicare Advantage (MA) risk-adjustment system determines payments for Medicare/Medicaid dually-eligible beneficiaries. We appreciate your staff's ongoing efforts to administer and improve payment systems for MA, particularly considering the competing demands on the agency.

The memorandum correctly notes that MedPAC has had concerns about the accuracy of the CMS-Hierarchical Condition Category (CMS-HCC) risk adjustment model for predicting costs of dually-eligible beneficiaries. The Commission's specific concern is that beneficiaries with full-dual eligibility (those beneficiaries eligible for full Medicaid benefits) incur significantly higher costs than beneficiaries with partial-dual eligibility (those whose Medicaid benefit consists only of assistance with Medicare premiums and, in some cases, Medicare cost sharing). Currently, the CMS-HCC system uses a single adjustment factor for dual eligibility status that is applied to both full- and partial-benefit dually eligible beneficiaries.

In place of this single adjustment, CMS proposes to use six separate models for community dwelling beneficiaries based on different categories of dual eligibility and reason for entitlement (aged or disabled), consistent with our concerns. CMS would continue to use a separate model for beneficiaries who have been in an institution for 90 days or longer. The CMS-HCC risk scores for community dwelling beneficiaries would be modeled separately for each of the following six groups:

1) Full benefit dual aged;
2) Full benefit dual disabled;
3) Partial benefit dual aged;
4) Partial benefit dual disabled;
5) Non-dual aged; and

6) Non-dual disabled.

We understand that each of the six models will produce different relative scores for each disease category, reflecting CMS's finding that disease is often treated differently for beneficiaries in different groups. While we have not analyzed relative disease scores within each group, we believe that CMS's finding is consistent with our work and are impressed with the strength of its predictive-ratio analyses. The predictive-ratio analyses show that the new system will be more accurate for beneficiaries in each of the six groups.

**Conclusion**

The Commission appreciates the opportunity to comment on the important policy proposals crafted by CMS. We also value the ongoing cooperation and collaboration between CMS and Commission staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact Mark E. Miller, the Commission's Executive Director.

Sincerely,

Francis J. Crosson M.D.

Francis J. Crosson, M.D.
Chairman